EMPLOYEE HEALTH EXPENSE REPORT
STATE HEALTH BENEFIT PLAN
P.O. Box 38151, Atlanta, Georgia 30334

INSTRUCTIONS: PRINT OR TYPE

Your claim *cannot be processed* unless you answer all the questions asked below and attach the PATIENT'S medical bill to this form. Turn to the reverse side for a listing of the specific information needed on the PATIENT'S medical bill**. NOTE: All claims must be submitted within 6 months of the date of service if SHBP is primary or within 12 months if we are the secondary coverage.**

EMPLOYEE INFORMATION

EMPLOYEE'S POLICY NUMBER

CAREFULLY COPY NUMBER FROM YOUR ID CARD

EMPLOYEE'S LAST NAME | FIRST

EMPLOYEE'S HOME ADDERSSS

CITY | STATE | ZIP

WORK PHONE NUMBER

PATIENT INFORMATION

PATIENT'S LAST NAME | FIRST

PATIENT'S SEX
- ☐ MALE
- ☐ FEMALE

PATIENT'S RELATIONSHIP TO EMPLOYEE
- ☐ SELF
- ☐ SPOUSE
- ☐ CHILD
- ☐ STEPCHILD
- ☐ OTHER CHILD

PATIENT'S BIRTHDAY MO | DAY | YR

If the PATIENT is a dependent child 19 years of age or older this claim cannot be considered for benefits unless proper documentation has been filed with the State Health Benefit Plan, Eligibility Unit.

DESCRIBE THE ILLNESS OR INJURY, WHICH REQUIRED TREATMENT.

_____ Date of First Treatment

_____ Date of Accident

COORDINATION OF BENEFITS

Is the PATIENT covered by any **other group health** insurance including another contract with the State Health Benefit Plan?

☐ YES ☐ NO If you checked YES, we must know the following information on the *other health* insurance company.

If we are the secondary plan (unless this is cross coverage with another State Health Benefit Plan member) you **must** attach a copy of the (a) bill showing dates and type of service, amounts of charges and diagnosis of illness along with (b) a statement from your other group health plan showing how much It paid for these services.

IF THE TREATMENT WAS FOR AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FLLOWING:

Was the accident related to the PATIENT'S employment? ☐ Yes ☐ No

Was the accident related to a motor vehicle accident? ☐ Yes ☐ No

EOB: Explanation of Benefits means the statement from your other health benefit group insurance showing the amounts paid for claims.

CHECK HERE IF THE EOB FOR THESE SERVICES IS ATTACHED.

☐ YES

POLICYHOLDER'S NAME | RELATIONSHIP TO PATIENT | INSURANCE COMPANY'S NAME

POLICY NUMBER | GROUP NUMBER | EFFECTIVE DATE | POLICYHOLDER'S EMPLOYER

INSURANCE COMPANY'S STREET ADDRESS | CITY | STATE | ZIP

EMPLOYEE'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical information necessary to process this claim and also certify the above information is correct.)

SIGNED | DATE

Is the PATIENT covered by:

MEDICARE PART A (HOSPITAL) ☐ Yes ☐ No

MEDICARE PART B (MEDICAL) ☐ Yes ☐ No

WARNING **Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law**

If the PATIENT has Medicare and is retired or is the spouse of a retired employee, this claim must be filed with Medicare before submitting it to us; however, nursing bills should be sent directly to us for processing. Be sure the Explanation of Medicare form you receive from Medicare contains the same totals and dates of service shown on your itemized statement. Send this form with the Medicare payment form and an itemized statement from your medical care provider to us. **EMPLOYEES WHO CONTINUE TO WORK BEYOND AGE 65 AND THEIR SPOUSES MUST FILE CLAIMS WITH US BEFORE FILING WITH MEDICARE.**

REQUIRED INFORMATION ON THE PATIENT'S MEDICAL BILLS TO PROCESS YOUR CLAIM

1. The name of the person or facility rendering the service or supply.
2. The PATIENT'S name *(person who received health care service or supplies).*
3. Each date that services or supplies were provided.
4. The charges for each service or supply received.
5. A description of each service or supply received.
6. Diagnosis or symptoms.
7. Bills for private duty nursing must show the nurse's professional status, *(Registered Nurse or Licensed Practical Nurse),* nurse's registry number, time of shift, date of service, and letter from the Doctor describing medical necessity.
8. Do not use this form for prescriptions. Express Scripts, Inc processes prescription bills. Prescription drug claim forms are available by calling Express Scripts at (877) 650-9342 or on the website, www.dch.state.ga.us. Payment of benefits will not be reimbursed to your doctor or hospital when using this form unless charges are incurred by a participating doctor/hospital.

WE CANNOT RETURN YOUR BILLS!
Make a copy of the PATIENT'S
medical bill before sending original to us.

Example of Itemized Statement

Dayton A. Penridge, M.D.
123 Fourth St.
Healthville, U.S.A.

J. E. Warrow
456 W. 25th St.
Healthville. U.S.A.

Diagnosis: Headache

For professional services
Rendered to:

Mrs. Virginia Warrow
5/13/75 Office Visit
Examination $ x.xx
Blood test $ x.xx

5/20/75 Office Visit
Provider's Name
Examination $ x.xx
Electrocardiogram $ x.xx
Total $xx.xx

1. Provider's Name
2. Insured's Name
3. Diagnosis
4. Patient's Name
5. Date of Service
6. Description of Service
7. Charges for Each Service

MAIL TO: State Health Benefit Plan
P.O. Box 38151
Atlanta, Georgia 30334

(Rev. 7/2003)